

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

15988

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15978

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN lb <b>2 weeks</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rehobeth</b>		17-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Edw. W. McCready Memo. Hospital</b>		d. STREET ADDRESS <b>---</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>ELLEN</b> Last <b>BELL</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>13</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 22, 1892</b>
9. AGE (In years last birthday) yrs. <b>75</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>13</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Evans</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Sidney C. Bell,</b>		Address <b>Rehobeth, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of gastric contents</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vascular insufficiency</b> DUE TO (c) <b>Congestive heart failure.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fractured right hip.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in hospital, fracturing right hip.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>9:30</b> p.m. <b>Nov. 12 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>McCready Hosp.</b>		20f. (City or town) (County) (State) <b>Crisfield Som. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>C. G. Rawley</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>C. G. Rawley, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Crisfield, Md.</b>	
22. DATE SIGNED <b>11/16/67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/17/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rehobeth Methodist</b>		23d. LOCATION (City or Town) (County) (State) <b>Rehobeth Som. Md.</b>	
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		ADDRESS <b>Pocomoke City, Md.</b>	
25a. REC'D BY REGISTRAR <b>NOV 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. C. H. Judge</b>	

12378

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

15987

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15979

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Princess Anne</b>		c. LENGTH OF STAY IN TB	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural; Princess Anne</b>		d. STREET ADDRESS <b>Route #2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Stephen Boston Sr.</b>		4. DATE OF DEATH Month Day Year <b>November 23 19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1893</b>
9. AGE (In years last birthday) yrs. <b>74</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Somerset Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Harmison Boston</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Laird</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Irene Boston, Princess Anne, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 4200			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 51</b> , 19 <b>51</b> , to <b>Oct 23</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Oct 15</b> , 19 <b>67</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>David J. Gilmore</b>		22b. DATE SIGNED <b>11/25/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>David J. Gilmore, M.d.</b>		22d. ADDRESS <b>Medical Center, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/25/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Andrew's</b>	23d. LOCATION (City or Town) (County) (State) <b>Princess Anne, Somerset Co</b>
24. FUNERAL DIRECTOR <b>James L. Linn</b>		25a. REC'D BY REGISTRAR <b>NOV 30 1967</b>	
ADDRESS <b>Princess Anne</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

2700.

1920. 11. 14.

2700.

1920. 11. 14.

1920. 11. 14.

1920. 11. 14.

1920. 11. 14.

1920. 11. 14.

1920. 11. 14.

1920. 11. 14.

1920. 11. 14.

1920. 11. 14.

1920. 11. 14.

1920. 11. 14.

1920. 11. 14.

1920. 11. 14.

1920. 11. 14.

1920. 11. 14.

1920. 11. 14.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15988

**CERTIFICATE OF DEATH**

15980

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b <b>4 Days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Girdletree</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McCready Memorial Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nona</b> Middle <b>V.</b> Last <b>Bowen</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>7</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1884</b>		9. AGE (In years last birthday) <b>83</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Tangier, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William R. Parks</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Crockett</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-56-2150</b>		17. INFORMANT <b>Mrs. Inez Butler, Crisfield, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular Disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <b>11/7/67</b> , 19____, and that death occurred at <b>7:40</b> AM, from causes and on the date stated above.							
22a. SIGNATURE <b>Sarah M. Peyton</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>S. M. Peyton, M.D.</b>				22d. ADDRESS <b>Crisfield, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/10/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Hopewell, Somerset, Md.</b>	
24. FUNERAL DIRECTOR <b>James Hanna</b>				ADDRESS <b>Princess Anne, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1950

OFFICE OF THE

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15989

**CERTIFICATE OF DEATH**

15981

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Somerset</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wenona</u>			c. LENGTH OF STAY IN 1b <u>10 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wenona</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>At home</u>				d. STREET ADDRESS <u>Main Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>William Edward Cavey</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Nov 5 19 67</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 19 1909</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrician</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clifton Cavey</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Roach</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Mrs Cora Cavey Wenona, Md 21821</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5min.</u> <u>years</u>	
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1969</u> 19 <u>19</u> , to <u>11-5-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-30-19 67</u> , and that death occurred at <u>11AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Everett Sutter MD</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11/7/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Everett Sutter MD</u>			22d. ADDRESS <u>Dames Quarter, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Paul's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Wenona Som MD</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Leroy Webster Princess Anne MD</u>			25a. REC'D BY REGISTRAR DATE <u>NOV 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

1974

UNITED STATES

1974

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

159980

159982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>		c. LENGTH OF STAY IN 1b <u>Marion Station</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>C.</u> Last <u>Mikes</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1878</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafood Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Westover, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harm Ward</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Steward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>217-01-8891</u>	
17. INFORMANT <u>Mrs. Minnie Ward</u> Address <u>Marion Station, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute dil. of heart -</u> DUE TO <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis - Chronic Int. Nephritis</u> DUE TO <u>General Atherosclerosis -</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>months -</u> <u>years -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Debility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Sept. 1967</u> to <u>Nov. 17, 1967</u> , that I last saw the deceased alive on <u>Nov. 16, 1967</u> , and that death occurred at <u>A-M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George C. Coulbourn M.D.</u>		ADDRESS (Street, city or town, state) <u>MARION STA., Md</u> DATE SIGNED <u>11/18-67</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE C. COULBOURN</u>		<u>MARION STATION - Md</u> <u>21838</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/19/67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Marion Sta., Som. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u> ADDRESS <u>Marion Sta., Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 21 1967</u>	24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH

1. Name of deceased  
2. Date of death  
3. Place of death  
4. Cause of death  
5. Signature of physician  
6. Signature of registrar  
7. Date of registration  
8. Place of registration

8

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 16. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15891

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1583

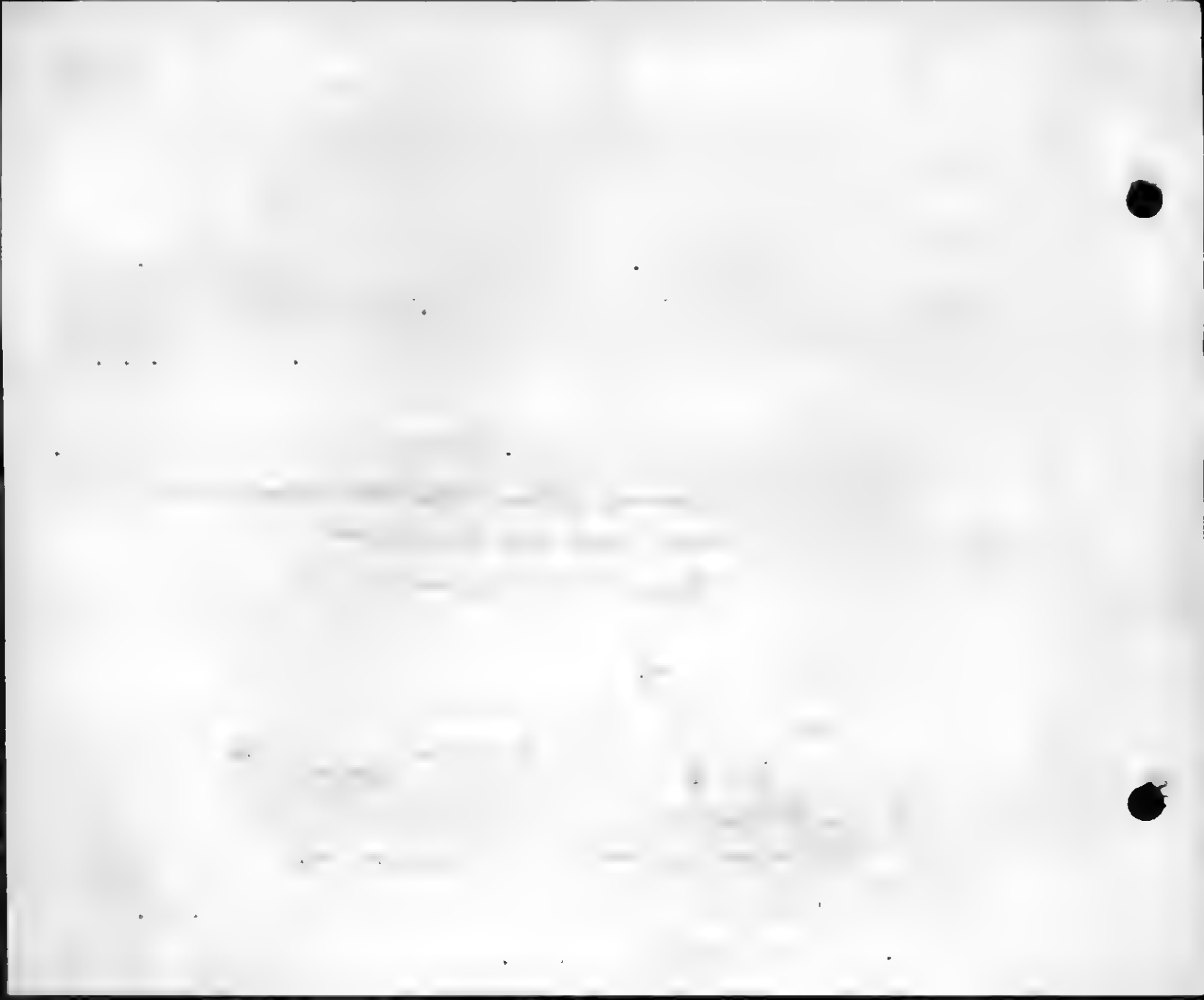
1 PLACE OF DEATH a COUNTY <b>Somerset</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Somerset</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c LENGTH OF STAY IN 1b <b>Adult life</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McCready Memorial Hospital (Outpatient)</b>				d STREET ADDRESS <b>Calvary Road</b>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>COLLINS</b> Last <b>PARKS</b>				4 DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>1967</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Dec. 30, 1915</b>	9 AGE (In years last birthday) <b>51</b> yrs	IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>15</b> Min <b>00</b>		IF UNDER 24 HRS Hours <b>15</b> Min <b>00</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>George Collins</b>				14 MOTHER'S MAIDEN NAME <b>Blanche Brittingham</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>218-03-4050</b>		17 INFORMANT Address <b>Allen Parks, Same as 2. abcd</b>			
18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>4-5 hrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>C. G. Rawley</b>		EXAMINER'S NAME (Type) <b>C. G. Rawley, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>11/6/67</b> <b>Crisfield, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>11/6/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Crisfield, Somerset, Md.</b>	
24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons, Crisfield, Md.</b>				25a REC'D BY REGISTRAR DATE <b>NOV 8 1967</b>		25b REGISTRAR'S SIGNATURE <i>Charles Jones</i>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5092  
CERTIFICATE OF DEATH  
19984

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FAIRMOUNT</b> c. LENGTH OF STAY IN ID <b>85 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FAIRMOUNT</b> d. STREET ADDRESS <b>101</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FLOSSIE P. RICHARDS</b>				4. DATE OF DEATH Month Day Year <b>NOV. 8 1967</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 3, 1882</b>	
9. AGE (In years last birthday) <b>85 yrs.</b>		10. FINDER 1 YEAR Months Days Hours Min.		11. FINDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>FAIRMOUNT, MD.</b>	
13. FATHER'S NAME <b>JAMES HEWITT</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH HEWITT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>				16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>		17. INFORMANT <b>MR. RUSSELL RICHARDS FAIRMOUNT, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Sclerosis</b> DUE TO (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Coronary Artery Sclerosis</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>11 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I (this hospital) attended the deceased from <b>past 30 days</b> , 19 <b>67</b> , to <b>11/8/67</b> , that I (we) last saw the deceased alive on <b>11-7-67</b> , 19 <b>67</b> , and that death occurred at <b>6:30 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>George C. Coulbourn</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>George C. Coulbourn</b>	
22d. ADDRESS <b>Maryland</b>				22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/12/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FAIRMOUNT CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>FAIRMOUNT, MD.</b>	
24. FUNERAL DIRECTOR <b>LEVIN R. WILSON PRINCESS ANNE, MD.</b>				25. DATE <b>NOV 13 1967</b>			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 151  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISTFIELD</b>		c. LENGTH OF STAY IN TB <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McCREADY HOSPITAL (DOA)</b>		d. STREET ADDRESS <b>RT-1</b>	
3 NAME OF DECEASED (Type or print) <b>CARRIE M. STERLING</b>		4 DATE OF DEATH Month <b>11</b> Day <b>12</b> Year <b>1967</b>	
5 SEX <b>F</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>SEPT. 11, 1899</b>
9. AGE (in years last birthday) <b>68</b> yrs		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>12</b> Hours <b>19</b> Mins <b>67</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (State or foreign country) <b>CRISTFIELD MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>JAMES COULBOURNE</b>		14 MOTHER'S MAIDEN NAME <b>ELLA TULL</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv ice) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-03-1486</b>	
17 INFORMANT <b>SAMUEL H. WILLIAMS - CRISTFIELD MD.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>SHOCK &amp; HEMORRHAGE</b> DUE TO (b) <b>MULTIPLE FRACTURES &amp; INTERNAL INJURIES</b> DUE TO (c) <b>FALL FROM</b>		INTERVAL BETWEEN ONSET AND DEATH <b>FEW MIN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>VIOLENTLY STRUCK BY AUTO</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>6:45</b> p.m. <b>11-12</b> 19 <b>67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>STREET</b>		20f. (City or town) (County) (State) <b>CRISTFIELD SOMERSET MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>A.N. BARR, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>A.N. BARR, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>CRISTFIELD</b>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>SOMERSET</b>	
		Address (Street, city, town, or county)	
23a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/15/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HARBURY</b>		23d. LOCATION (City or Town) (County) (State) <b>CRISTFIELD MD.</b>	
24 FUNERAL DIRECTOR <b>Anthony E. Ward Cristfield MD.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
		DATE NOV 15 1967	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15994

CERTIFICATE OF DEATH

15986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>			c. LENGTH OF STAY IN 1b <b>24 Days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McCreedy Memorial Hospital</b>				d. STREET ADDRESS <b>20 Maryland Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>W.</b> Last <b>Todd</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>23</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1889</b>	9. AGE (In years lost birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Holland's Island, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William W. Parks</b>				14. MOTHER'S MAIDEN NAME <b>Rosina McCoy</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-32-7449</b>		17. INFORMANT Address <b>Miss Hilda Todd, same as 2 abcd above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Cardiac Infarction (myocardial)</b> DUE TO (b) <b>Cardio-Vascular insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>7 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>o.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>2:10</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/23/67</b> 19 <b>67</b> , and that death occurred on <b>2:10</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>S. M. Peyton</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>S. M. Peyton M.D.</b>				22d. ADDRESS <b>Crisfield, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 26, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Crisfield, Md.</b>	
24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons -- Crisfield, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>O. Charles Judge</b>	

25031

REMARKS ON CASE

25031

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

REMARKS ON CASE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15995

CERTIFICATE OF DEATH

15987

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>			c. LENGTH OF STAY IN lb <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McCready Memorial Hospital</b>				d. STREET ADDRESS <b>RT # 1 Box 303</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Willie</b> Middle <b>C</b> Last <b>Ward</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>27</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/10/1893</b>	9. AGE (In years lost birthday) yrs. <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seefood Worker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Marion Sta. Som. Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		
13. FATHER'S NAME <b>Joshua Ward</b>			14. MOTHER'S MAIDEN NAME <b>Avintha (Unknown)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-03-7597</b>		17. INFORMANT <b>Mrs. Minnie Ward - Marion Sta., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Wound</b> DUE TO (b) <b>Choke Out while Chasing Mynards</b> DUE TO (c) <b>Gunshot Arteries</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gunshot Arteries</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 15</b> , 19 <b>67</b> , to <b>Nov 27</b> , 19 <b>67</b> , and that death occurred at <b>1:40</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>G. C. Coulbourn MD</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>G. C. Coulbourn, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/29/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Family</b>		23d. LOCATION (City or Town) (County) (State) <b>Marion Sta., Md. 21838</b>	
24. FUNERAL DIRECTOR <b>Charles H. Ward - Marion Sta., Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1887

1887

1887

James Ward  
1887

1887

1887